Appendix 16
Request for Reimbursement for OBRA Level I Screening

WISCONSIN MEDICAL ASSISTANCE
REQUEST FOR REIMBURSEMENT FOR OBRA LEVEL I SCREENING

Provider Name: _____

Medical Assistance Provider Number: _____

1. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

---

2. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

---

3. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

---

4. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

---

5. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

---

6. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

CERTIFICATION:
This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents or concealment of material fact, may be prosecuted under applicable federal or state laws.

Signature _____ Date _____